

Case Number:	CM13-0030840		
Date Assigned:	03/17/2014	Date of Injury:	04/02/2009
Decision Date:	05/23/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 29 year old female with a date of injury of 4/02/2009. The most recent medical record, a pain management progress report, dated 8/05/2013, lists subjective complaints as constant pain and discomfort in her back and sharp, aching, and constant pain in her knees, left more than right. Patient continues to have diminished kidney function. She also states memory problems, dizziness and fatigue. Prolonged walking and standing worsen the pain. There is no physical examination documented at the time of the request. The most recent physical examination provided in the medical records, was performed on 05/13/2013, and revealed decreased range of motion of the lumbar spine and decreased motor strength of the lower extremities. Examination of the left knee revealed no gross edema not palpable warmth. Patient was unable to demonstrate heel and toe walking. Diagnosis: 1. Thoracic spine sprain/strain syndrome 2. Chronic thoracic spine facet joint arthropathy 3. Cervical and lumbar spine strain/sprain syndrome secondary to mid back/thoracic spine injury 4. Left knee joint arthropathy. The patient was seen by a Qualified Medical Examiner (QME) on 07/31/2013, who stated that the patient appeared over medicated with opiates and that she was unable to give a coherent history. The patient admitted at that time that she used multiple opiate medications on an ongoing and chronic basis. The medical records provided for review document that the patient has been on the following medications for at least as far back as 9/19/2013. Medications: 1. Duragesic patch 75mcg #15, SIG: 1 patch every 48 hours 2. Morphine Sulfate 20mg #900, SIG: 1-2 tid 3. Valium 5mg #30, SIG: 1 tab po qd 4. Balcofen 5mg #90, SIG: 1 tab po tid 5. Colace 150mg #30, SIG: 1 tab po qd-bid

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

RETROSPECTIVE REQUEST FOR ACTIQ 400MCG, ONE (1) UNIT THREE (3) TIMES DAILY AS NEEDED FOR BREAKTHROUGH PAIN: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: Actiq is a fentanyl citrate lozenge indicated for the management of breakthrough pain in cancer patients who are tolerant to around-the-clock opioid therapy. In a 07/31/2013 QME report, the physician documents that the patient was over-medicated to the point that she was unable to give a coherent medical history. She is already receiving transdermal fentanyl and oral morphine. Additional oral fentanyl is unwarranted and not medically necessary.